DEPARTMENT OF HEALTH AND FAMILY SERVICES
Division of Public Health
DPH 4671 (Rev. 07/03)

STATE OF WISCONSIN
Bureau of Family & Community Health
WIC Program
Federal Reg. 246

BREASTFEEDING & NON-BREASTFEEDING POSTPARTUM QUESTIONNAIRE

Participation in WIC is voluntary. Personally identifiable information is used to determine WIC eligibility and may be disclosed to others only as allowed by state and federal laws.

INSTRUCTIONS: Please check your answer or fill in the blank. If you don't know an answer, leave it blank.

Your First and Last Name _____ Today's Date _____

Your Birth Date _____ Where have you been on WIC before? _____

In school, what was the last grade you completed, if known (GED = 12th grade)? _____

* **If you were on WIC at this WIC project during your pregnancy, skip the questions marked with the star (*).**

1. Check the programs you use now:

☐ W-2, TANF	(a)	☐ School Lunch or Summer Food Program	(d)
☐ Food Stamps or Commodity Foods	(c)	☐ Health Check (EPSDT)	(g)
☐ Family Planning	(e)	☐ Prenatal Care Coordination	(f)
☐ Extension Nutrition Education Program (EFNEP or FNP)	(j)	☐ Other _____	(l)
☐ SSI or Katie Beckett	(b)		

2. Check how your health care is paid for:

☐ Medicaid/Healthy Start/Badger Care	(a)	☐ No insurance	(g)
☐ Insurance - co-pay or deductible	(c)	☐ Indian Health or Migrant Health	(c)
☐ Insurance with exclusions or restrictions	(h)	☐ Other government source	(d)
☐ Insurance - full coverage	(e)		

3. When was your baby born? _____

4. What did your baby weigh at birth? _____ Was this a twin or other multiple birth? ☐ Yes ☐ No

* 5. When did you first see your doctor or midwife for this pregnancy (don't count just pregnancy test or vitamin prescription)? (date) _____

6. What is the name of your doctor/midwife? _____ Clinic _____

7. When was your last dental visit? _____

* 8. How much did you weigh before you became pregnant this time? _____ Pounds ☐ Don't know

9. How much weight did you gain while you were pregnant? _____ Pounds

* 10. Were you ever pregnant before this time? ☐ Yes ☐ No (If no, go to question #11)

How many babies have you given birth to? _____ Any twins or other multiple births? ☐ Yes ☐ No

When did the pregnancy before this one end? (include miscarriages, abortions, stillbirths)? Date _____

11. Check any health problems that a doctor has told you that you have now or that you had during your pregnancy:

☐ Food allergy	☐ Bad teeth or sore gums	☐ Stress
☐ Lactose intolerance	☐ HIV/AIDS	☐ Flu-like feeling
☐ Heart disease	☐ Anorexia/bulimia	☐ Diarrhea
☐ Kidney disease	☐ C-Section	☐ Constipation
☐ Diabetes	☐ Depression	☐ Other _____
☐ High blood pressure		

12. Have you had any illness or surgery in the last six months? ☐ Yes ☐ No

    If yes, what was the illness or surgery? _____

13. Do you take any prescribed medicine? ☐ Yes ☐ No If yes, what do you take? _____

14. Are you taking a vitamin or mineral supplement? ☐ Yes ☐ No

15. Check any of these that you take:

    ☐ Antacids ☐ Laxatives ☐ Fiber supplements
    ☐ Smokeless or chewing tobacco ☐ Cocaine, pot or other street drugs ☐ Herbs
    ☐ Home remedies ☐ Diet pills ☐ Other _____
    ☐ Water pills

16. Does anyone in your household smoke? ☐ Yes ☐ No

17. During the 3 months **before** you were pregnant, how many cigarettes per day did you smoke? _____

18. During the **last** 3 months you were pregnant, how many cigarettes per day did you smoke? _____

19. How many cigarettes a day do you smoke **now**? _____ Are you trying to quit? ☐ Yes ☐ No

20. During the 3 months **before** you were pregnant, how many days a week did you drink beer, wine or liquor? _____ How many drinks a day did you have? _____

21. During the **last** 3 months of pregnancy, how many days a week did you drink beer, wine or liquor? _____

    How many drinks a day do you have? _____

22. How many days a week do you drink beer, wine, or liquor **now**? _____ How many drinks a day do you have? _____

23. In the past 6 months, have you felt threatened or been emotionally, verbally, or physically abused by your partner or someone close to you? ☐ Yes ☐ No

24. What would you like your weight to be? _____ Pounds

25. Check the topics for which you would like more information:

    ☐ Birth Control/Family Planning ☐ Quitting smoking ☐ Weight loss/gain
    ☐ How to get health care for you/new baby ☐ Alcohol or drug use

Answer these questions if you are breastfeeding. If you are <u>not</u> breastfeeding, go to the next page.

1. How old was your baby when your milk came in? _____ Days
2. How many times in 24 hours (day and night) do you breastfeed your baby? _____
3. How many wet diapers does your baby have in a day? (24 hours)? _____
4. How many stools does your baby have in a day (24 hours)? _____
5. Does your baby drink anything besides breastmilk? ☐ Yes ☐ No
6. How long do you plan to breastfeed your baby? _____
7. Are you having any breast discomfort or pain? ☐ Yes ☐ No
8. Does your **baby** have any problems with breastfeeding? ☐ Yes ☐ No
9. Will you be going to work or school ☐ Yes ☐ No ____ If yes, when? _____
10. Do you plan to express your breastmilk? ☐ Yes ☐ No Do you need a breast pump? ☐ Yes ☐ No
11. What questions do you have about breastfeeding or expressing your milk? _____

    _____

WOMAN'S FOOD RECORD

Name _____ Today's Date _____

For the last 24 hours, write down everything you **ate** or **drank** (meals and snacks). Start with the first time you ate yesterday, to the first time you ate today.

TIME	PLACE	AMOUNT AND FOOD/BEVERAGE EATEN
EXAMPLE:		
10:30 a.m.	home	1 cup cornflakes cereal with ½ cup lowfat milk, 4 oz. apple juice
Noon	home	sandwich - 2 slices whole wheat bread, 2 slices cheddar cheese, and 1 tablespoon butter 1 cup (8 oz.) tomato soup made with lowfat milk

Office Use Only: Bread: Frt: Veg: Milk: Meat:

1. Is this the way you eat most of the time? ☐ Yes ☐ No

   If no, why? _____

2. What foods do you refuse to eat? _____

3. How often do you eat away from home? ☐ 1 to 2 times a week ☐ 2 to 4 times a week ☐ almost every day

   Where are these meals eaten? _____

4. Are you on a diet, following diet restrictions, or trying to control your weight? ☐ Yes ☐ No

5. How is your appetite? ☐ Good ☐ Fair ☐ Poor

6. Circle the foods you ate or drank in the last three days:

Beef	Orange, grapefruit	Broccoli	Tea
Hamburger	Orange or grapefruit juice	Spinach, bok choy	Coffee
Pork	Strawberries	Greens (mustard, collard)	
Chicken	Pineapple/pineapple juice	Potatoes	Soda pop
Turkey	WIC Approved* apple juice	Cabbage, cole slaw	Flavored drink mix
Wild game	WIC Approved* grape juice	Green pepper	Hot chocolate
Tuna	WIC Approved* juice blends	Cauliflower	
Other fish, dried fish	WIC Approved* calcium-fortified juice	Tomato or tomato juice	
Liver, liverwurst	Watermelon	Carrots	
Peanut butter	Cantaloupe	Dark yellow squash	
WIC approved* cereals	Papaya, mango	Sweet potatoes	
Dried beans/ peas	Peaches, apricots	Pumpkin	
Peanuts/other nuts	Other fruits_____	Other vegetables_____	
Tofu	_____	_____	
Eggs			

Milk	White bread	Hot dogs	Chips
Cheese	Muffin	Sausage	Candy
Yogurt	Tortilla	Lunch meats	Gelatin
Ice Cream	Bun	Egg rolls	Cookies
Pudding	Rice	TV dinners	Donuts
Pizza	Rice skins	Pot pies	Cake, cupcakes
Tacos	Noodles	Canned meals like spaghettios	Popsicle
Enchiladas	Dark bread	Box meals like macaroni & cheese	
Lasagna	Pancakes	Canned soup	
Cheeseburger	Crackers		

*A list of WIC Approved cereals and juices is available from the local WIC Project

7. Do you ever eat rare meat, raw milk, raw fish, or raw or soft-cooked eggs? ☐ Yes ☐ No
8. Do you eat fish caught in Wisconsin lakes and rivers? ☐ Yes ☐ No
9. Do you ever go more than 12 hours without eating? ☐ Yes ☐ No
10. Did you have any problems last month getting enough food? ☐ Yes ☐ No
11. If you are short of money for food, what foods do you give up? _____
12. What foods do you think you should eat more of? _____
13. Who buys the food? _____ Who cooks the food? _____
14. Are meals planned? ☐ Yes ☐ No If yes, who plans the meals? _____
15. What working appliances do you have to make or store food? ☐ Stove ☐ Refrigerator ☐ Microwave ☐ Blender or food grinder
16. Where do you usually eat? ☐ Kitchen/dining table ☐ Living/TV room ☐ Other
17. Where does your drinking water usually come from? ☐ Well ☐ City water ☐ Bottled ☐ Don't know

    If well water, when was the last time it was tested? _____